

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-031162

FILED VS AUG 23 1960

Registration District No. 170 Primary Registration District No. — Registrar's No. 122

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>LACLEDE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>LACLEDE</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LEBANON</u>		Length of stay in 1b <u>11 YRS.</u>		c. CITY OR TOWN <u>LEBANON</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>OAKLAND STR. ROUTE</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>OAKLAND STR. RT</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>FRED</u> Middle <u>LONG</u> Last <u>LONG</u>				4. DATE OF DEATH Month <u>AUG.</u> Day <u>11</u> Year <u>1960</u>					
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9-20-24</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILROAD</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (City and state or country) <u>ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Joseph L. Long</u>			13b. MOTHER'S MAIDEN NAME <u>ROSSETA CLESSON</u>			14. NAME OF HUSBAND OR WIFE <u>Byrd Jones Long</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS. S.H. GREEN, LEBANON, Mo.</u>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)						
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>3-8-54</u> to <u>5-7-60</u> and last saw <u>her</u> alive on <u>5-7-60</u>				Death occurred at <u>5:45</u> <u>1</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>B B Hurst, MD</u>				22b. ADDRESS <u>Lebanon, Mo.</u>		22c. DATE SIGNED <u>8-15-60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8-13-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. ROSE</u>		23d. LOCATION (City, town, or county) <u>LEBANON</u>		23e. STATE <u>Mo.</u>			
24. FUNERAL DIRECTOR <u>A J Shadel</u>			ADDRESS <u>Lebanon, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8-19-1960</u>		26. REGISTRAR'S SIGNATURE <u>Della L. May</u>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 29 1960

AUG 23 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____
Gene P. Hunter

Licensed Embalmer No. *4739*

P. O. Address *Spfld, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.